

Group Health Benefits at a Glance

Plan Feature	Group Health Gold	Group Health Silver	Group Health Bronze
<i>Provider choice</i>	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There's no coverage for out-of-network care unless indicated and approved/referred.		
<i>Annual deductible</i>	None		
<i>Copay, unless otherwise indicated</i>	You pay \$20	You pay \$35	You pay \$50
<i>After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum</i>	Network: 100% Out-of-network: Limited emergency/out-of-area care		
<i>Annual out-of-pocket maximum</i>	Network: \$1,000/ person or \$2,000/ family Out-of-network: Limited emergency/out-of-area care	Network: \$2,000/ person or \$4,000/ family Out-of-network: Limited emergency/out-of-area care	Network: \$3,000/ person or \$6,000/ family Out-of-network: Limited emergency/out-of-area care
<i>After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level</i>	Network only: 100%		
<i>Lifetime maximum</i>	No limit		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<i>Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)</i>	Self-referrals to a network provider: \$20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: \$35 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: \$50 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.
<i>Ambulance services</i>	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<i>Chemical dependency treatment (requires preauthorization)</i>	<i>For inpatient care:</i> 100% after \$200 copay/admission <i>For outpatient care:</i> 100% after \$20 copay/visit	<i>For inpatient care:</i> 100% after \$400 copay/admission <i>For outpatient care:</i> 100% after \$35 copay/visit	<i>For inpatient care:</i> 100% after \$600 copay/admission <i>For outpatient care:</i> 100% after \$50 copay/visit
<i>Chiropractic care and manipulative therapy (like all services, must be medically necessary)</i>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<i>Diabetes care training</i>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<i>Diabetes supplies (insulin, needles, syringes, lancets, etc.)</i>	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
<i>Durable medical equipment, prosthetics and orthopedic appliances</i>	80% when preauthorized	50% when preauthorized	50% when preauthorized
<i>Emergency room care</i>	Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$200 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived but \$200 copay/admission for hospital care applies if admitted) Non-emergency care is not covered.	Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$400 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived, but \$400 copay/admission for hospital care applies if admitted) Non-emergency care is not covered.	Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$600 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived, but \$600 copay/admission for hospital care applies if admitted) Non-emergency care is not covered.
<i>Family planning</i>	100% after \$20 copay/visit Infertility treatment is not covered.	100% after \$35 copay/visit Infertility treatment is not covered.	100% after \$50 copay/visit Infertility treatment is not covered.
<i>Growth hormones</i>	Covered under prescription drugs if medical coverage has been continuous for more than 12 months under this plan whether or not the growth disorder existed before plan coverage		
<i>Hearing aids</i>	100%, up to \$300/ear in 36 months		
<i>Home health care</i>	100%		
<i>Hospice care</i>	100% when preauthorized Certain limits apply; call plan for details.		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
Hospital care	100% after \$200 copay/admission	100% after \$400 copay/admission	100% after \$600 copay/admission
Inpatient care alternatives	100% when preauthorized		
Lab, X-ray and other diagnostic testing	100%		
Maternity care	<i>For delivery and related hospital care:</i> 100% after \$200 copay/admission <i>For prenatal and postpartum care:</i> 100% after \$20 copay/visit	<i>For delivery and related hospital care:</i> 100% after \$400 copay/admission <i>For prenatal and postpartum care:</i> 100% after \$35 copay/visit	<i>For delivery and related hospital care:</i> 100% after \$800 copay/admission <i>For prenatal and postpartum care:</i> 100% after \$50 copay/visit
Mental health care (requires preauthorization)	<i>For inpatient care:</i> 100% after \$200 copay per admission <i>For outpatient care:</i> 100% after \$20 copay/individual, family, couple or group session	<i>For inpatient care:</i> 100% after \$400 copay per admission <i>For outpatient care:</i> 100% after \$35 copay/individual, family, couple or group session	<i>For inpatient care:</i> 100% after \$600 copay per admission <i>For outpatient care:</i> 100% after \$50 copay/individual, family, couple or group session
Neurodevelopmental therapy for covered dependents age 6 and under	<i>For inpatient care:</i> 100% after \$200 copay/admission, up to 60 days/year (combined with rehabilitative services) <i>For outpatient care:</i> 100% after \$20 copay/visit, up to 60 visits/year (combined with rehabilitative services)	<i>For inpatient care:</i> 100% after \$400 copay/admission, up to 60 days/year (combined with rehabilitative services) <i>For outpatient care:</i> 100% after \$35 copay/visit, up to 60 visits/year (combined with rehabilitative services)	<i>For inpatient care:</i> 100% after \$600 copay/admission, up to 60 days/year (combined with rehabilitative services) <i>For outpatient care:</i> 100% after \$50 copay/visit, up to 60 visits/year (combined with rehabilitative services)
Out-of-area coverage—for example, while traveling or for your covered children away at school	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.		
Phenylketonuria (PKU) formula	100%		
Physician and other medical/surgical services	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$20 copay/office visit	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$35 copay/office visit	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$50 copay/office visit

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<i>Prescription drugs—Up to a 30-day supply through network pharmacies</i>	Generic: 100% after \$10 copay Preferred brand: 100% after \$20 copay Non-preferred brand: 100% after \$30 copay Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.		
<i>Prescription drug—Up to a 90-day supply through mail-order network only</i>	Generic: 100% after \$20 copay Preferred brand: 100% after \$40 copay Non-preferred brand: 100% after \$60 copay		
<i>Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)</i>	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)
<i>Radiation therapy, chemotherapy and respiratory therapy</i>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<i>Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.</i>	100% depending on services provided; copays may apply (including \$200 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including \$400 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including \$600 copay/admission if hospital care is required)
<i>Rehabilitative services—Inpatient and outpatient</i>	<i>For inpatient care:</i> 100% after \$200 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) <i>For outpatient care:</i> 100% after \$20 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	<i>For inpatient care:</i> 100% after \$400 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) <i>For outpatient care:</i> 100% after \$35 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	<i>For inpatient care:</i> 100% after \$600 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy) <i>For outpatient care:</i> 100% after \$50 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)
<i>Skilled nursing facility</i>	100% up to 60 days/calendar year at a Group Health-approved nursing facility		

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<i>Smoking cessation</i>	100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Free & Clear® Quit for Life™ Program, when prescribed by Group Health PCP No annual or lifetime limit		
<i>Temporomandibular joint (TMJ) disorders</i>	<i>For inpatient care:</i> 100% after \$200 copay/admission <i>For outpatient care:</i> 100% after \$20 copay/visit Up to \$1,000/calendar year and a \$5,000 lifetime maximum	<i>For inpatient care:</i> 100% after \$400 copay/admission <i>For outpatient care:</i> 100% after \$35 copay/visit Up to \$1,000/calendar year and a \$5,000 lifetime maximum	<i>For inpatient care:</i> 100% after \$600 copay/admission <i>For outpatient care:</i> 100% after \$50 copay/visit Up to \$1,000/calendar year and a \$5,000 lifetime maximum
<i>Transplants (certain services only)</i>	100% after applicable copays Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered.		
<i>Urgent care (ear infections, high fevers, minor burns)</i>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<i>Vision exams</i>	100% after \$20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after \$35 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after \$50 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)